CONSORTIUM
for
CITIZENS
with
DISABILITIES

June 24, 2003

The Honorable Dennis Hastert
Speaker
House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
House of Representatives
Washington, DC 20515

Dear Speaker Hastert and Minority Leader Pelosi:

The undersigned organizations of the Consortium for Citizens with Disabilities (CCD) wish to express our concerns on the pending Medicare legislation that seeks to create a prescription drug benefit and restructure the Medicare delivery system. The disability community is pleased that Congress is considering ways to provide prescription drugs to Medicare beneficiaries, but we are very concerned that the House bill seeks to privatize the Medicare delivery system in order to administer this new benefit in a manner that has significant potential to negatively affect access to quality health care for persons with disabilities and chronic illnesses. We also have significant concerns with the widespread use of competitive bidding in the fee-for-service program.

The CCD Health Task Force advocates for health care reform from a disability perspective. We measure all major health reform proposals against a set of five principles: Nondiscrimination, Comprehensiveness, Appropriateness, Equity and Efficiency.

There are nearly six million Medicare beneficiaries with disabilities under the age of 65, totaling approximately 14 percent of the Medicare population. These beneficiaries are more likely than seniors to lack adequate coverage for prescription drugs. While access to prescription drugs is very important, maintaining and improving access to quality health care through traditional fee-for-service Medicare is equally crucial. In contrast, the House bill systematically undercuts the integrity of the fee-for-service system and, over time, will ultimately destroy one of Medicare's most popular and successful features.

People with disabilities should not be left with no other option but to enroll in a managed care plan simply to access improved prescription benefits. Medicare

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beneficiaries have had the ability to choose managed care through the Medicare+Choice program since 1997 and six years later, 87% have chosen to stay in the fee-for-service program. Since 1997, 2.4 million Medicare beneficiaries have been forced to find new providers of care when their HMO pulled out of the Medicare program. The fee-for-service program has never dropped a single enrollee in its 37 years of existence.

Under the House proposal, the fee-for-service Medicare program would be forced to operate like a private insurance plan. It would set its premiums based on its costs and bid for Medicare beneficiaries against HMO and PPO plans offered by private insurance companies. Making Medicare function more like a private insurance market threatens to unravel the best aspects of the Medicare program and will likely result in underservice to beneficiaries who have greater than average needs.

After 2010, beneficiaries who choose to stay in the fee-for-service program will be forced to pay more than they otherwise would because the fee-for-service Medicare program enrolls beneficiaries that, on average, require more frequent and intensive services than those in private plans. For instance, the Urban Institute has found that while 13.8 percent of Medicare beneficiaries enrolled in the fee-for-service Medicare program had both cognitive and physical difficulties, only 6.6 percent of Medicare HMO enrollees reported such conditions. The cost differences in caring for beneficiaries with cognitive and physical disabilities compared to those without these conditions was dramatic in 1997 - $20,332 versus $5,037.

This type of "cherry-picking" by private plans undermines the social insurance nature of the Medicare program and would ultimately lead to significant cost increases for beneficiaries under the fee-for-service program as such beneficiaries become more highly concentrated in traditional Medicare. Those unable to afford the cost of staying in fee-for-service Medicare will eventually be forced to enroll in a PPO or HMO.

This trend would be highly detrimental to beneficiaries with disabilities and chronic illnesses. Studies have shown that people with disabilities in managed care plans have less access to specialists and limited choices of doctors.[1] Access to a doctor of choice and particular specialists is very important for a person with a disability to achieve the best outcome possible, thus attaining independence and the ability to function to the maximum extent. In addition, managed care typically has less market penetration in rural areas, thus rendering choice of provider even more restrictive for people with disabilities in these areas.[2]

As case studies have shown for people with disabilities, the impact of using managed care "cost-saving models" in health care delivery can "backfire" in the long

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[1]Neri, M.T., Kroll, T. *Disability and Rehabilitation*, 2003, vol. 25, 85-96. "Understanding the consequences of access barriers to health care: experiences of adults with disabilities." Iezzone, L., Davis, R., Soukup, J., O'Day, B. *International Journal for Quality in Health Care* 2002, vol. 14, no. 5, 369-381. "Satisfaction with quality and access to health care among people with disabling conditions."

[2] McCloskey, A., *Families USA*, May 2003. "Managed Care Plans Offer No Real Choice for Rural Medicare Beneficiaries."

term. Under managed care models, beneficiaries with disabilities are often treated for their acute care needs. What is not routinely covered, however, are treatments that are needed to "maintain function and to prevent complications, functional decline, and secondary conditions."[3] Not only can the health of people with disabilities be negatively affected by managed care, more expensive services are often required in the end—at a higher cost to the health plan.

Under managed care plans, a number of critical rehabilitation services are often highly managed, resulting in restricted access for people with disabilities and chronic illnesses. For instance, managed care plans often divert patients with intensive medical rehabilitation needs to skilled nursing facilities rather than inpatient rehabilitation hospitals where intensive rehabilitation care can be provided. The range of rehabilitation therapies afforded to patients with physical disabilities is often restricted and access to appropriate mobility and other devices is routinely curtailed. The long term outcome of these policies is, more often than not, greater cost of treatment and lesser functional status of the beneficiary.

Mental health care benefits are also more difficult to obtain in a managed care setting. Persons seeking treatment for mental illness consistently receive better access to treatment and therapy through fee-for-service health plans than through managed care.[4] Moreover, Medicare currently imposes a highly discriminatory provision requiring a 50% co-payment for mental health services instead of the standard 20% co-payment for outpatient services that greatly impairs access to critical treatment. The 50% co-payment blocks beneficiaries from accessing care by mental health providers with the expertise necessary to effectively prescribe medication, provide therapy, and other services essential to recovery. The 50% co-payment is grounded in stigma and we call for its repeal.

Finally, we oppose the House's proposal to use "competitive bidding" in the fee-for-service program for both durable medical equipment and disease management services. Durable medical equipment is essential for Medicare beneficiaries to remain as functional and as independent as possible. Competitive bidding of DME will result in beneficiaries being forced to choose a provider from a "closed panel" of low bidders. We believe this proposal will result in lesser quality of care, restricted access to the full range of DME, and interruptions in long-standing patient/provider relationships. Rather than taking billions of dollars over the next decade from the DME benefit, Congress should be focused on enhancing coverage to address unmet needs in the assistive device area, such as hearing aids, more functional mobility devices, vision devices, and a whole host of other assistive devices and technologies.

Disease management can offer important benefits to beneficiaries with chronic conditions or extensive health care needs such as coordination of benefits and services, identification of the right service at the right time, and, ultimately, cost savings. But the implementation of disease management under the fee-for-service program through competitive bidding immediately focuses the case manager on cost

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[3] Neri, M.T., *et al.*
[4] McCloskey, A., *et al.*

savings, rather than effective management of the patient's condition and superior outcomes. Competitively bidding of disease management services ultimately creates a condition-specific HMO within the fee-for-service program, bringing all of the same concerns that we have with the provision of Medicare benefits through private managed care plans.

As the House continues to craft a Medicare drug benefit that incorporates private managed care plans as a means for the provision of all health care delivery and employs widespread use of competitive bidding in the fee-for-service program, we ask you to consider our principles of nondiscrimination, comprehensiveness, appropriateness, equity, and efficiency, and the disproportionate effect such reforms will have on beneficiaries with disabilities and chronic illnesses.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Association of People with Disabilities
American Association on Mental Retardation
American Council of the Blind
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Network of Community Options and Resources
Association of Academic Physiatrists
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Center on Disability and Health
Disability Service Providers of America
Easter Seals
Helen Keller National Center
National Association for the Advancement of Orthotics and Prosthetics
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Coalition on Deaf-Blindness
National Mental Health Association
National Respite Coalition
Paralyzed Veterans of America
The Arc of the United States
Title II Community AIDS National Network
United Cerebral Palsy
World Institute on Disability

cc: Chairman William Thomas, Ways and Means Committee
Ranking Member Charles Rangel, Ways and Means Committee
Chairman Billy Tauzin, Energy and Commerce Committee
Ranking Member John Dingell, Energy and Commerce Committee